TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PINE CREEK MEDICAL CENTER

Respondent Name
TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

MFDR Tracking Number
M4-18-0410-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
October 16, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 12/13/16 a corrected claim was submitted to Travelers. . . . I was advised the claim denied as a duplicate/error . . . the appeal denied again indicating the corrected did not request for separate reimbursement. . . . I am requesting assistance from the TDI/DWC to resolve this matter as Pine Creek Medical Center remains under paid per the fee schedule/MAR."

Amount in Dispute: $2,507.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reviewed the billing and reimbursed the Provider 200% of the Medicare rate . . . The Provider subsequently submitted a 'corrected' bill, increasing the billed amount in 5 of the 11 codes billed and adding a 12th code . . . as well as requesting separate reimbursement of implantables. This is not a corrected bill, but rather a new bill and the Carrier denied the bill as a duplicate of the bill previously submitted for this date of service. The Provider submitted a request for reconsideration of the 'corrected' bill, but not on the original bill. . . . The Provider is not entitled to Medical Fee Dispute Resolution on the 'corrected' bill. The bill for which the Provider seeks Medical Fee Dispute Resolution is a duplicate of the properly and timely submitted original bill for this date of service. It is not a corrected bill, as it contained new billed amounts and new billed services constituting new billing for this date of service. As the Provider had previously submitted billing for this date of service and been reimbursed, and the Provider is not seeking Medical Fee Dispute Resolution on that bill, the Provider is not entitled to Medical Fee Dispute Resolution on this duplicative and abusive billing."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 17, 2016	Outpatient Hospital Services	$2,507.73	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 96 – NONCOVERED CHARGE(S).
   - 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
   - 582 – BASED ON MEDICARE SCHEDULE, STATUS INDICATES THIS CODE IS EITHER AN INVALID OR DELETED CPT/HCPCS CODE. MEDICARE USES ANOTHER CODE FOR REPORTING OF, AND PAYMENT FOR, THIS CODE. PLEASE RE-SUBMIT THE APPROPRIATE CODE TO ENSURE ACCURATE PROCESSING.
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.

Issues

1. May the health care provider submit a corrected claim to the insurance carrier?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards reimbursement for hospital facility services related to an outpatient surgery. After sending the initial billing, the health care provider submitted a "corrected claim" identified using bill type 137 in box 4 of the UB-04 claim form, indicating "Replacement of a prior outpatient hospital claim."

   The respondent argues that:

   > The Provider subsequently submitted a 'corrected' bill, increasing the billed amount in 5 of the 11 codes billed and adding a 12th code . . . as well as requesting separate reimbursement of implantables. This is not a corrected bill, but rather a new bill and the Carrier denied the bill as a duplicate of the bill previously submitted for this date of service. The Provider submitted a request for reconsideration of the 'corrected' bill, but not on the original bill. . . . The Provider is not entitled to Medical Fee Dispute Resolution on the 'corrected' bill. The bill for which the Provider seeks Medical Fee Dispute Resolution is a duplicate of the properly and timely submitted original bill for this date of service. It is not a corrected bill, as it contained new billed amounts and new billed services constituting new billing for this date of service. As the Provider had previously submitted billing for this date of service and been reimbursed, and the Provider is not seeking Medical Fee Dispute Resolution on that bill, the Provider is not entitled to Medical Fee Dispute Resolution on this duplicative and abusive billing.

   28 Texas Administrative Code §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified by division rules.

   Medicare payment policies allow medical providers the opportunity to correct errors or omissions in a submitted claim without the need to initiate a formal appeal—as outlined in *Medicare Claims Processing Manual*, Publication 100-4, Chapter 1 - *General Billing Requirements*, §§ 80.3.2 - *Handling Incomplete or Invalid Claims* and 70.2.3.1 - *Incomplete or Invalid Submissions*, and as further reflected in CMS educational materials such as *Medicare Learning Network (MLN) Matters* article SE0420, regarding Section 937 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-73, which explains procedures for correction of claims errors and omissions without appeals.

Nothing in the division's rules prohibits a health care provider from submitting a corrected claim, so long as it is timely submitted and otherwise meets rule requirements. Insofar as material changes have been made to the codes and dollar amounts reported, the respondent is correct that such a claim is considered a "new" bill. As such, It is not appropriate for the insurance carrier to deny the corrected bill as a "duplicate" with respect to the material changes in the billing.

It is not necessary for the provider to appeal the original claims submission, as that bill is no longer in dispute. The health care provider *has* requested reconsideration on the corrected claim—which includes the disputed services for which Medical Fee Dispute Resolution is requested. This dispute is therefore eligible for review by MFDR.

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount (including outlier payments) applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from http://www.cms.gov.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Review of the submitted information finds that the provider requested separate payment for implantables. Therefore, per Rule §134.403(f)(1)(B), the facility specific amount including outlier payments is multiplied by 130 percent. Per Rule §134.403(f)(2), when calculating outlier payments, the facility's total billed charges shall be reduced by the billed charges for any item reimbursed separately under Rule §134.403(g). The total billed charges for the separately paid implantables are $24,568.20. Accordingly, the total billed charges shall be reduced by this amount when calculating outlier payments.

3. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure codes 82962 and 84703 have status indicator Q4, denoting packaged labs; reimbursement is included with APC payment for the primary services. This service is not separately paid.
   - Per Medicare payment policy regarding correct coding (NCCI) edits, procedure code 76000 may not be reported with code 64450 billed on this same claim. Reimbursement for this service is included with payment for the primary procedure. Separate payment is not recommended.
   - Procedure code 28740 has status indicator J1, denoting packaged services paid at a comprehensive APC rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This service is assigned APC 5124. The OPPS Addendum A rate is $7,064.07. This is multiplied by 60% for an unadjusted labor-related amount of $4,238.44, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $4,151.13. The non-labor related portion is 40% of the APC rate, or $2,825.63. The sum of the labor and non-labor portions is $6,976.76. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the fixed-dollar threshold of $3,250, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.203. This ratio is multiplied by the billed charge of $26,055.00 for a cost of $5,289.17. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $6,976.76 divided by the sum of APC payments is 100.00%. The sum of packaged costs is $2,736.85. The allocated portion of packaged costs is $2,736.85, which is added to the service cost for a total cost of $8,026.02. The cost of services exceeds the fixed-dollar threshold of $3,250. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The Medicare facility specific amount of $6,976.76, is multiplied by 130% for a MAR of $9,069.79.
   - Per Medicare payment policy, reimbursement for "T" status procedure code 38220 is bundled with the payment for the primary "J1" service, procedure code 28740 above. Separate payment is not recommended.

- Per Medicare payment policy regarding correct coding (NCCI) edits, procedure code 64450 may not be reported with codes 28740 and 38220 billed on the same date. Payment is further bundled with reimbursement for "J1" code 28740 above. Reimbursement for this service is included with payment for the primary procedures. Separate payment is not recommended.
- Procedure code S0020 was not a valid Medicare billing code on the date of service. It further represents an item for which reimbursement is bundled with payment for "J1" code 28740. Separate payment is not recommended.
- Procedure code J2704 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.

4. Additionally, the provider requested separate reimbursement of implantables. Per Rule §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds the following implantables:
   - The only implantable item billed for which payment is supported is "IMP DBM 5CC PUTTY (EXACTCH)" as identified in the itemized statement and on the invoice as "OPTECURE WITH CCC - 5CC," with a cost per unit of $656.00.
   - The respondent did not provide invoices or other documentation to support a cost per unit of the following implantable items as listed on the itemized statement:
     "PLATE (T10) POLYAXIEL LOCK MID"
     "IMP STRY FIXATION PINS", 2 units
     "SCREW 3.5X28MM LOCKING
     "SCREW 3.5X24MM LOCKING"
     "IMP STY SCR 3.5 X 22MM LOCKNG"
     "SCR 3.5X30 LOCKING"
     "SCREW 4.1X34MM CP LAG"
   - Per Rule §134.403(b)(2), "implantable" means an object or device that is surgically: (a) implanted, (b) embedded, (c) inserted, (d) or otherwise applied, and (e) related equipment necessary to operate, program and recharge the implantable. The health care provider submitted an invoice for "Surgical Tools for Erythrocyte & Marrow Prep Kit." Review of the submitted information finds insufficient documentation to support that this item meets the definition of an implantable under Rule §134.403(b)(2). Separate reimbursement is not recommended.

   The total net invoice amount (exclusive of rebates and discounts) is $656.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $65.60. The total recommended reimbursement amount for the implantable items is $721.60.

5. The total recommended reimbursement for the disputed services is $9,791.39. The insurance carrier has paid $12,093.10, leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	November 10, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.